

**AUTHORIZATION FOR USE/DISCLOSURE OF
PROTECTED HEALTH INFORMATION
MENTAL HEALTH SERVICES ACT
HOUSING PROGRAMS**

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

I authorize the use and disclosure of my Protected Health Information (PHI) as described below:

CLIENT/INDIVIDUAL IDENTIFICATION

First Name

Last Name

Street Address

City, State, Zip

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IS Number

Birth Date

Phone Number

DISCLOSING PARTY - RECIPIENT OF PHI

This authorization allows: Los Angeles County Department of Mental Health (LACDMH) to use, receive and/or disclose my PHI, as described below, to housing developers, property management agencies, onsite service providers and/or property owners in reference to referrals for permanent housing or the implementation and administration of LACDMH's funded or sponsored housing programs or projects including but not limited to the MHSA Housing Trust Fund or MHSA Housing Programs.

REDISCLOSURE NOTICE:

I understand that my PHI that is used or disclosed pursuant to this Authorization may no longer be protected by Federal Law and could be further used or disclosed by the recipient without my authorization. I also understand that once my information is disclosed, it may not be possible to retrieve.

DESCRIPTION OF PHI & PURPOSE

Description of PHI to be Used, Received and/or Disclosed:

Information contained in the MHSA Housing Tenant Certification Application such as verification of disability, and acknowledgment of currently receiving mental health services, demographics, income, current address, social security number, employment information and any additional information that would assist an individual/family applying for rental housing. In addition, any information required for data collection and monitoring such as duration of housing stay, income, and frequency, type and financial value of mental health services or services offered through the onsite service provider.

Purpose of Disclosure:

My PHI may be used for eligibility determination for LACDMH funded or sponsored housing projects or programs, assistance with locating and/or maintaining housing, advocacy with property owners or property management staff and to comply with data collection and monitoring requirements of LACDMH funded and/or sponsored housing programs or projects.

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Neither LACDMH nor any person signing this Authorization will receive any direct or indirect remuneration.

NOTICE

COPY OF THIS AUTHORIZATION: I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.

CONDITIONS: I understand that I may refuse to sign this Authorization without affecting my ability to obtain treatment. *LACDMH will not take any intimidating or retaliatory acts against anyone who does not wish to disclose their PHI or sign this Authorization.*

EXPIRATION DATE

Expiration Date: This authorization remains valid until the person residing in a LACDMH funded or sponsored unit formally and/or permanently vacates occupancy

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

Signature of Client/Individual/Personal Representative

Date

If signed by other than client, state relationship and authority to do so:

REVOCATION OF AUTHORIZATION: I understand that I have the right to revoke this authorization at any time in writing. I may use the Revocation of Authorization Section of this form, mail or deliver the revocation to **LACDMH Countywide Housing, Employment, and Education Resource Development Housing Policy and Development Unit, 695 S. Vermont Ave., 10th Floor, Los Angeles, CA 90005**. I also understand that a revocation will be effective upon receipt, but will not be effective as to uses and/or disclosures of my protected health information already made in reliance on this Authorization.

REVOCATION OF AUTHORIZATION

Signature of Client/Individual/Personal Representative

Date

If signed by other than client, state relationship and authority to do so: